PEOPLES HEALTH

January 28, 2013

VIA ELECTRONIC AND HAND DELIVERY
ELECTRONIC: louann.owen@la.gov

Lou Ann Owen
Medicaid Deputy Director
Louisiana Department of Health and Hospitals
628 N 4th St.
Bienville Building 7th Floor (70802)
Baton Rouge, LA 70821-9030

RE: Medicaid Long Term Services and Supports RFI

Dear Ms. Owen,

Attached please find our response to your request for information regarding Long Term Services and Support for persons enrolled in Louisiana Medicaid. We appreciate your interest in our input in your efforts to improve and enhance the existing service model for the dually-eligible population.

Please feel free to contact me if you or your staff would like for us to clarify any of our suggestions or provide you with any of the documents we referenced in our response. We would welcome the opportunity to assist the Department in any way you feel would be appropriate as you move forward.

Sincerely,

Carol Solomon
Chief Executive Officer

Enclosure

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PEOPLES HEALTH

MEDICAID LONG TERM SERVICES AND SUPPORTS RFI

- Background

Peoples Health was established in 1994, and currently provides over 50,000 Southeast Louisiana residents with their Medicare benefit. Peoples Health is a health plan licensed in the State of Louisiana, fully accredited (URAC), and has a long standing Medicare Advantage contract with the federal Centers for Medicare and Medicaid Services (CMS).

This company is a physician owned company, specifically designed to service Louisiana residents and has been recognized nationally for innovative solutions that support the members' health and vitality. A service area expansion in 2005 allowed Peoples Health to service the entire greater New Orleans area. In 2007, Peoples Health further expanded the service area to include a total of 14 parishes, including the Baton Rouge market. As of January 2013, nine more parishes have been added to the coverage area, spanning from Lafourche and Terrebonne Parishes along the coast, to St. Helena and Feliciana Parishes along the Mississippi border. That expansion will bring the service area of Peoples Health to 23 parishes. This includes a population of 2.5 million, a Medicare eligible market of 379,000 and dual-eligible market of approximately 100,000. In 2007, Peoples Health was granted a Special Needs Plan (SNP) to serve the dual-eligible market. That market has grown to over 10,000 members, representing a D-SNP market share of 20% in our 2012 service area.

We appreciate the opportunity to respond to the Department of Health and Hospitals Request for Information and feel we are well qualified to assist you in achieving your objectives for persons enrolled in Louisiana Medicaid who are receiving Long Term Services and Supports. Our specific responses to your request follow and include our existing approach to management of acute care services for the dual-eligible population and the services we are developing for the efficient delivery of long term care supports and services.

- Population to be Included

The population we would be interested in serving are the currently non-managed dual-eligibles and Medicaid only recipients receiving Acute Care Services only, Acute Care Services and Home and Community Based Services as well as Acute Care Services in Home and Community Based Services and Facility Services in the Department of Health and Hospitals administrative Regions, 1, 2, 3, and 9.

- Best Enrollment Model for Program

Peoples Health would suggest that the Department utilize the enrollment procedures it used for the implementation of Bayou Health, with some modification of the pre-enrollment education component to address the special needs of the population. Under a Medicare enrollment waiver, any dual-eligible member that currently belongs to a Medicare Advantage Plan offered at or below the Low Income

premium subsidy amount and participating in the demonstration be auto assigned to their current MA Plan. This option would preserve the voluntary choice made by the enrollee in selecting a plan to provider their Medicare benefits. Further, it would promote continuity of care for the enrollee allowing them to continue care from their current provider network, as well as continued participation in any care management and or disease management programs they currently participate in under their MA plan. Those persons who are not auto assigned to an existing MA plan and fail to make a choice between the participating plans should be auto-assigned on a rotating basis to the participating plans. The plans should complete the enrollment and initial orientation process prior to the effective date for implementation of the programs. The enrollment waiver from CMS should also require an auto enrollment into the assigned plans Medicare Advantage program. Having a single Plan responsible for the provison and coordination of care for such a vulnerable population should produce better care outcomes, medical compliance, and utilization. Perhaps preference would be given to those plans offering a Special Needs product. Plans should be limited to pre-enrollment marketing efforts permitted by Medicare. Those persons who chose or are assigned to Peoples Health would be enrolled in our Peoples Health Medicare Advantage Plan (Special Needs Plan) with optional provisions similar to those used in Bayou Health.

- Support and Services (Medicaid and non-Medicaid)

We believe that our approach to managing care for the dual-eligibles we currently serve provides an effective model for recipient support and service delivery. Peoples Health now includes in our care model the ownership and operation of primary care centers. This Patient Centered Medical Home strategy incorporates the key objectives for primary care centers recognized by the National Committee for Quality Assurance.

Our model follows the five point principles of an effective medical home which are:

Patient-Centered – Our medical home is located in a physician practice (which may be owned and staffed by Peoples Health physicians and staff). These practices are near the major hospitals used by the members they serve. The plan is to have all of those facilities immediately accessible to the hospital, to facilitate a smoother transition from hospital to the medical home and facilitate the efficient use of nearby outpatient services and hospital resources. The entire design places the patient at the center of the delivery system.

Comprehensive – The design includes the concept of a wellness center, which addresses keeping the member healthy through proactive wellness measures, a service center, which will address all of the services a member needs that can assist the member in staying healthy. The ultimate goal is to start early with the member to avoid repeated emergency room visits, hospitalization, or the need for long term care facilities.

Coordinated – All of the medical support staff and social service staff within the medical home are the employees of Peoples Health. This model further assures coordination of services since the need for communication with outside resources is reduced. Within the hospitals, Peoples Health has a staff of contracted hospitalists who oversee the inpatient stay along with Peoples Health Registered Nurses and Social Workers who assist with the discharge planning to assure the transition from hospital to home is seamless. This team arranges the patient's first outpatient physician visit and other necessary follow up before the patient leaves the hospital.

As an integral part of the plan's integrated Medical Management program, regional Interdisciplinary Care Teams (ICTs) have been established throughout the plan's service area. The ICTs are designed to coordinate care for the plan's members throughout the healthcare continuum and ensure appropriate treatment and the coordination of the delivery of services and benefits. Each member is assigned to a regional ICT based on their geographic location in the plan's service area. The members of the ICT are selected based on their expertise in the social, chronic care, and disease management aspects of their individual disciplines in order to address the unique needs of the dual-eligible population.

Each regional ICT is overseen by a Regional Administrator (Registered Nurse) who is responsible for the overall coordination of care of the members assigned to the team and managed by a Field Supervisor. Inpatient Nurses and Social Workers are engaged in the day-to-day coordination of care for the members who are admitted into acute settings, skilled nursing, and rehabilitation facilities. They assess the member during the acute stay and work with the Inpatient Authorization Coordinators to prepare them for discharge services (like durable medical equipment and Home Health) or transition to another level of care. Outpatient Case Managers and Social Workers are responsible for the ongoing case management and social services needs of the member in their daily activities once they are out of the inpatient setting. Both inpatient and outpatient nurses and social workers are designated as "Care Coordinators". The team also includes a dedicated clinical pharmacist to assist with medication reviews. This team supports the primary care provider and completes the "Medical Home".

As the Care Coordinators assess and address member needs, they create an Individualized Care Plan (ICP) with the member and/or caregiver through their various member assessments. They will present and discuss important changes to the member's care plan in monthly regional Interdisciplinary Care Team (ICT) meetings, which include participation from all members of the ICT when needed. The ICT will make suggestions to update or revise ICPs as needed to maximize the member's health outcome. The ICT will also review communication strategies, frequency of communications, service standards for, assessments and administrative data. Minutes taken from each meeting will document decisions made and directives related to the member's ICP. The Care Coordinators will communicate the decisions of the ICT and revisions of the ICP to the member and his/her family through face-to-face consultation or telephonically. The ICP, changes to the ICP, and documentation of ICT suggestions and member communication is documented in Care Enhanced Care Management System (CCMS), the plan's care management documentation and authorization system. The ICT members and Primary Care Physicians have access to the ICPs through CCMS and Member Viewer, the plan's secured, web-based, comprehensive portal that reflects the variety of services delivered to the member. These systems provide up-to-date information on a member's ICP. Concerns and/or suggestions from the member/caregiver regarding the ICP are communicated back to the ICT via the Care Coordinators. The Care Coordinator is responsible for revising the care plan to the agreement of the ICT and member/caregiver and ensuring the member/caregiver understands their ongoing access to this information and the ICT.

Accessible –Peoples Health provides a medical transportation benefit to members. This benefit further assures that the patient will have adequate access to their medical care providers. As noted earlier, we are also developing these medical homes near community hospitals. We individually contact members to remind them of medical appointments and make sure transportation is not an issue by developing a backup plan if needed.

System-Based Approach to Quality and Safety – All of our systems help assure quality care that is safely administered. Our staff is a double check for each other; creating a system of checks and balances, working as a team with our plan employed physicians and our broader network of community providers. We are aware that many private practice physicians have spent a significant portion of their professional careers developing their practice; they are now looking for help. We have recognized their experience, knowledge and clinical expertise are highly valued by patients, peers, and within the community, however many independent practitioners do not have the time, resources, or ability to invest in transitioning their practice to fully capitalize on a pay for performance reimbursement model. As an integrated delivery system, Peoples Health is in a unique position to meet the demand and opportunity in this new environment as we have all of the systems (technical, medical, and social) in place to work with this community of physicians.

- <u>How we provide the needed supports and services for our members</u>

This model has been designed to address the physical, mental, nutritional, and psychosocial needs of the dual eligible population. Essentially, the process starts at the time of enrollment, at which time a comprehensive care plan is developed for the member.

Once the comprehensive care plan is completed, the member is assigned a medical home (primary care physician), who is responsible for implementing the plan of care. In this model, our health plan and clinicians place the member/patient in the center of the individualized special needs health care system – for both support services and clinical outcomes. Planners and Providers must share the diagnostic and treatment strategies and information needed to effectively coordinate and deliver preventive, acute, and chronic care. As previously stated, in order to effectively coordinate care and manage the delivery of services, each member is assigned to a regional Interdisciplinary Care Team (ICT) based on their geographic location in the plan's service area. Each regional team is overseen by a regional administrator (registered nurse) who is responsible for the overall coordination of care for the members assigned to the teams in each region. The Field Supervisor monitors the field teams and reports back to the Regional Administrator. The field teams within the region are comprised of inpatient and outpatient teams of nurses and social workers who operate as "Care Coordinators" responsible for managing the delivery of care to address the member's needs.

More specifically, the members of the care coordination team include:

- Outpatient and Inpatient Care Coordinators (case managers) who are licensed registered nurses (includes transplant and wound care coordinators)
- Outpatient, Inpatient and SNF/LTAC Social Workers, who are LCSW or LCSW eligible
- Disease Management Coordinators who are licensed registered nurses

- Clinical Pharmacists who must be licensed as a registered pharmacist
- Corporate Dietitian who must be licensed as a dietitian/nutritionist
- Nurse Practitioners

The inpatient care coordinators manage the care for members who are admitted to inpatient acute settings, skilled nursing facilities and rehabilitation facilities. The inpatient team is comprised of Inpatient Nurses who monitor the member's inpatient clinical course; Inpatient Social Workers who evaluate the reasons the member was admitted and help assess the member's discharge needs; and Inpatient Authorization Nurse Coordinators who manage home health and durable medical equipment services. There are also SNF/LTAC Nurses and Inpatient Social Workers who coordinate admissions to skilled nursing facilities, long-term acute care facilities and rehabilitation facilities. The outpatient team of Nurse Case Managers and Outpatient Social Workers are responsible for the ongoing clinical and social case management needs of the plan member. All transitions of care are conducted within the regional team.

These Care Coordinators (registered nurses and clinical social workers) collaborate with the Primary Care Physician (PCP), specialists, interdisciplinary care review team, contracted mental health specialists and family/caregivers when necessary to meet the member's needs in a proactive manner designed to prevent adverse outcomes and avoidable episodes of care. They advocate, inform and educate beneficiaries; identify and facilitate access to community resources; triage care needs through comprehensive assessments; obtain consultation and diagnostic reports when applicable; and facilitate appointment scheduling, transportation, home health, and follow-up services when applicable. These staff members also make appropriate referrals to case management or one of the Chronic Care programs (Chronic Kidney Disease/ESRD, COPD, Heart Failure, or Diabetes programs).

The plan's Nurse Practitioner provides support, additional resources and home visits to some of the member population who are homebound or who do not have easy access to physician offices for care and treatment. The Nurse Practitioners also support the plan's PCP offices by providing extra help and resources to assist with patient care and health care delivery.

The Transplant Coordinator and Wound Care Coordinator provide additional support in this model to members who have special needs for transplant and wound care services. Central to these partnerships are reducing expensive emergency room visits and unnecessary hospital stays. There is also a joint focus on producing well-documented quality measures; detailed and complete diagnostic coding, and consistent, efficient billing and payment processes.

The new federal health legislation, the trend of fewer residents choosing to become primary care physicians and a growing, aging population in Southeast Louisiana also make access to primary care services a top priority. Recognizing these challenges, our Administrative and Clinical Oversight processes are as follows:

The SNP Program Director is responsible for the following:

- Develops, implements and oversees all policies and procedures related to the plan and the model of care;
- Monitors management services contracts that directly impact the model of care;

- Evaluates the model of care's effectiveness by analyzing and acting on outcome measures;
- Monitors the Interdisciplinary Care Team by attending meetings and/or reviewing minutes of the meetings to ensure effective care coordination and transitions across settings and providers; and
- Assures the services and benefits outlined in the Individualized Care Plan is communicated to members effectively and timely and is reviewed on an ongoing basis.

The Vice President of Health Services (a Nurse Practitioner) and the Assistant Vice President of Medical Management Operations (Registered Nurse) oversee the authorization review process for specific services such as all inpatient admissions, home health, outpatient surgery services and durable medical equipment, to ensure medical appropriateness based upon guidelines established by CMS, InterQual, and the plan's Practice Guidelines and Medical Necessity Policies.

The Vice President of Medical Affairs (MD) and the plan's Medical Directors oversee the medical operations of each area and review certain requested services for medical necessity in working in conjunction with the medical review.

These physicians are all members of the plan's Quality, Policy, and Credentialing (QPC) committee that oversees the medical management and quality programs.

The Quality Improvement (QI) Coordinator, under the direction of the QI Director and QI Manager, both registered nurses, oversee and administer the Medicare Quality Improvement Program and projects. They set goals for each project and provide baseline measurements and benchmarks. They perform measurements according to their established schedule and annual QI Workplan. They also perform audits of medical record documentation in contracted physician offices to ensure the continuity of quality patient care by providers within the network (e.g., QI staff visits each medical office of contracted physicians bi-annually and conducts a computer generated random selection of 10 members per office). They also oversee the data collection and processes for Healthcare Effectiveness Data and Information Set, (HEDIS) Health Outcomes Survey (HOS) and Consumer Assessment of Health Plans Study (CAHPS) administration and implement improvement activities where needed. They also research and investigate quality referrals from within the organization. All QI program activity is reported to the QPC Committee which is also responsible for approving the annual QI Workplan. Department management is responsible for oversight and reporting information and issues to the appropriate departments within the organization.

Pharmacy Clinical Operations are managed by Clinical Pharmacists who oversee formulary management, medication review and the CMS mandated Medication Therapy Management Program (MTMP). MTMP is designed to ensure optimum therapeutic outcomes for targeted beneficiaries with chronic diseases and to reduce the risk of adverse effects. The MTMP is coordinated with the plan's chronic care improvement programs. Members are offered a comprehensive medication review performed by a pharmacist and are counseled on their medication profile. Interventions also include prescribers to help facilitate changes in the member's medication profile. Prescribers are educated on medication therapy options based on available clinical evidence. Department management is responsible for oversight and reporting information and issues to the appropriate departments within the organization.

The Compliance program is under the direction of the Compliance Officer who provides oversight for the plan's Compliance Program by assuring that the plan meets and follows all statutory and

regulatory guidance as dictated by CMS and other regulatory agencies through the Compliance and Fraud, Waste and Abuse Programs and initiatives. The Compliance Regulatory and Guidance unit has Regulatory Compliance Coordinators who are responsible for the dissemination of CMS and other regulatory guidance to PHN departments and ensuring implementation into PHN department processes and policies. They are also responsible for regulatory training and education, and policy and procedure development. Training and education is provided according to assessed risk and is also based on monitoring and auditing results. Training and education materials are posted on the plan's internal website to ensure all staff has easy access to CMS regulatory information. The Compliance Monitoring and Oversight unit has Oversight Coordinators who are responsible for internal monitoring of all operational areas, ensuring prompt responses to identified deficiencies and developing corrective actions. Department management is responsible for oversight and reporting information and issues to the appropriate departments within the organization.

Network Development Contracting and Credentialing Specialists ensure all newly contracted providers and ancillary providers employed by the organization successfully complete the credentialing process upon approval of their contract. Additionally, these providers are re-credentialed every three years. Upon completion of a successful credentialing/re-credentialing process, the provider is approved by the QPC Committee. Department management is responsible for oversight and reporting information and issues to the appropriate departments within the organization.

Provider licenses are reviewed for expiration/renewal on a monthly basis and the credentialing policies are reviewed annually to assure compliance with CMS requirements. Provider files are reviewed to ensure any action taken by the State Medical Society and/or CMS that would prevent or limit the provider's ability to service its members are considered before the renewal is approved.

The QPC Committee is comprised of network physicians and management personnel, whose role is to annually develop, implement, oversee and evaluate the QI Program.

The QPC Committee meets on a monthly basis and has a variety of functions including, but not limited to, the review and approval of evidence-based practice guidelines for use by the plan's network of providers and ensuring that the plan's providers have current licensure and competency, as established through the credentialing process. There are several sub-committees under this committee such as the Pharmacy and Therapeutics Committee and Medical Management Committee. The QPC Committee also monitors and reviews utilization reports, identifies and determines action on opportunities for improvement or changes to the Medical Management and QI Program.

- <u>Approach to Conflict-Free Case Management</u>

We would form an approach where the Department would retain responsibility for determining the eligibility for participation in Home and Community based services and the resource allocation to address the member's needs. Beyond that function, the only method that would work without flaw is for Peoples Health to totally Case Manage the eligible population. This would mean that the dual-eligible recipients assigned would have to be discharged from any case management companies they are currently assigned. We would require members utilize our existing model for care plan development, revisions prior to care plan, quality review, etc.

- Inclusion of Behavioral Health

Currently, Peoples Health outsources its behavioral health component of the plans. Our current provider is Optum, however we would be happy to use any provider the State chooses, as long as that provider is willing to contract with us at a reasonable rate. We are aware that the State currently uses Magellan as their behavioral health provider. We have started discussions with Magellan to reach an understanding that will assure coordination of care that ensures appropriate service delivery and continuity of care and maximizes cost efficiency.

Our current assessment process to determine the needs of a patient in need of behavioral health assistance is as follows: At the time of completing an Individual Case Plan, the Clinical Social Worker addresses the need for the patient to have mental health services. This assessment is done through observation, an interview with family and/or caregivers, and a review of the patient's history of mental health needs. Once that determination is made, the social worker refers to the mental health network.

The plan has over 35 licensed clinical social workers on staff. Members may encounter a Social Worker in four aspects of the continuum of care, including at an acute inpatient hospital setting, skilled nursing facility (SNF) and/or Long Term Acute Care (LTAC) setting, community based Personal Health Exam, or an outpatient home-based setting. In the context of settings, the primary role of the Social Worker is to help identify needs related to several key life areas such as: access to care, financial, caregiver support system, mental/emotional health, chronic conditions/complex health needs, health education/literacy, frail/disabled and end of life concerns. Utilizing an initial psychosocial assessment geared towards assessing needs in the life areas identified above, the Social Worker works with the member to develop mutually agreed upon goals, provide support and education regarding health plan navigation, and the need for linkage to community resources.

The plan has a substantial network of mental health providers, including over 100 psychiatrists, who are sub-contracted through a mental health services vendor. Plan members are provided information on accessing this network through a variety of communications including the Evidence of Coverage, Provider Directory, and other plan materials. The plan meets with the Mental Health Services vendor weekly to discuss administrative concerns and members who are at high risk for readmission.

Behavioral health provider network changes are reviewed monthly by the Network Development department to monitor activity. The entire network is reviewed semi- annually in depth by both the plan and the mental health services vendor. During the weekly member rounds call with the vendor, the Social Services Manager and the Nurse Case Manager, discuss specific member related issues.

Written protocols and evidence-based practice guidelines are reviewed annually by the Guidelines and Policy Subcommittee and are approved by the QPC Committee.

The plan will collect, report, and analyze outcome and process measures data to help improve beneficiary outcomes.

- How the system will use evidence-based best practices for treatment and patient care

Our medical home model, as previously stated, was designed to address the total needs of the patient which includes the physical, social, nutritional, and psychosocial needs.

We recognize that our members are fathers and mothers; members of a broader community, and that the physical well-being of the member is largely dependent on their contact and interaction within the community in which they live. Because we recognize that need, Peoples Health has begun to develop adult day centers which are accessible to all our members. These centers include medical services and socialization opportunities. To assure participation, we have included daily transportation to those programs. As we noted previously, our Quality Improvement and Quality Assurance processes are imbedded in our service delivery models and our Quality, Policy, and Credentialing Committee is responsible for assuring that our protocols are evidence based and reflect current best practices.

- Identify Partnerships

As stated above, we have already begun developing partnerships to expand service to the dual eligible population. In New Orleans, we are collaborating with the Archdioceses of New Orleans in setting up our own adult day care centers. John Young, the President of Jefferson Parish, has committed to work with us in developing a center in Jefferson and the Mayor of Baton Rouge, Kip Holden, has committed to working with us and help bring a corporate partner to the table (Coca-Cola). We will work with DHH, various Home and Community based provider associations and their members to identify high-quality providers with whom we can contract to provide services not currently available in our network. We have already reached out to Volunteers of America in the greater New Orleans area to begin discussions regarding the delivery of Long Term Care Personal Care Services.

As we expand in 2013 into other parishes, we will be meeting with the stakeholders in those areas to form new and additional alliances.

- Education and Outreach

The plan will offer the following services to improve access to preventive services:

- Members are invited to health fairs offering free preventive screenings such as a BMI assessment, Bone Mineral Density scan for all women to check for osteoporosis, FOBT kit for colorectal cancer screenings, Spirometry testing to screen for COPD, Cholesterol screening, blood pressure screening, Diabetes screenings including HbA1c, LDL, and Nephropathy.
    - The plan schedules several Health Fairs each quarter, throughout its service area.
    - Members who have not engaged in preventive care services are invited and encouraged to get the needed services, at no cost to the member.
    - Free transportation is provided for the member to the health fairs.
    - Health fairs include a nurse, social worker, and pharmacist, to offer additional assistance as needed.
    - Some health fairs may be held at health clubs or wellness clinics where the member can register to use their free membership and engage in healthy exercise and lifestyle programs.

If a member is unable to attend a health fair the member may be contacted and offered assistance in scheduling services such as eye exams and mammograms, including free transportation; and the plan

may offer to provide certain key screenings at no charge in the member's home, such as spirometry to confirm COPD and a bone mineral density scan after a fracture to verify a diagnosis of osteoporosis and prescribe treatment.

- Free flu shot clinics with free transportation are offered with additional preventive services at the events.
    - Members may also receive free flu shots at local drugstores, or their physicians' offices.
- Other initiatives such as working with providers to contact members that need screenings to schedule appointments and coordinate care.

For the services listed below the goal is to achieve a minimum 75th percentile for the NCQA means and percentile rankings for each measure in the Healthcare Effectiveness Data and Information Set (HEDIS) compliance rate from the 2010 plan baseline for the following measures to ensure members are getting the preventative care recommended by CMS:

- Colorectal Cancer Screening
- Glaucoma Screening in Older Adults
- Care for Older Adults
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Pharmacotherapy of COPD Exacerbation
- Controlling High Blood Pressure
- Persistence of Beta-Blocker Treatment After a Heart Attack
- Osteoporosis Management in Older Women
- Antidepressant Medication Management
- Follow-Up After Hospitalization for Mental Illness
- Annual Monitoring for Patients on Persistent Medications
- Potentially Harmful Drug-Disease Interactions
- Use of High-Risk Medications in the Elderly
- Medication Reconciliation Post-Discharge
- Comprehensive Diabetes Care

An additional goal is to achieve a 4% increase from the 2010 baseline in flu shot utilization and a 5% increase for the pneumonia vaccine in order to keep the member healthy by reducing the chances that a member will get the flu and be admitted into the hospital.

Reports are reviewed by the SNP Program Director and the Director of Performance Improvement to determine if member compliance is increasing to satisfy the set goals. The reports are run monthly and include the most recent compliance rate for the HEDIS measures. A list of members that have not received the necessary services is also available and used for planning future health fairs.

The plan also conducts annual wellness physicals at special health fair clinics periodically throughout the year. The members who attend can receive a comprehensive physical from a Nurse Practitioner, an assessment by a social worker, pharmacist, and a physician. Prior to the physical, members are scheduled for a laboratory appointment that includes a comprehensive blood test including: CBC, hemoglobin A1C, urinalysis, and blood screenings for certain cancers such as PSA. An example of the effectiveness of these annual wellness physicals is illustrated as follows: Prior to attending the clinic, one of the plan members had reportedly not seen a physician in two years and was living in a house that was half caved in due to a fire a few months earlier. He was out of testing supplies and came to the clinic to "get help with his diabetes." The prescreen lab work showed the member was positive for prostate cancer and that it was advanced. The member is currently receiving treatment coordinated by a plan case manager and a social worker has linked to him to resources for home repair and shelter in the community. The member has also made some advanced planning for his health care. If not detected, member may have been so progressed that treatment would only be palliative at best and not curative as it is now.

If the goal to increase HEDIS preventive measure scores is not met the SNP Program Director and the Director of Performance Improvement will re-assess the health fair program. Each aspect of the program will be evaluated to determine if modifications to the program would address identified weaknesses. For example, if they determine the measures are not being met because attendance is poor they will try to determine what would improve attendance considering things such as where the events are held, how often, and the method of communicating the event to members. Program adjustments will be made and result re-measured.

If the goal to increase the number of members receiving a flu shot is not met the Director of Performance Improvement will re-assess the different options members currently have for getting the vaccine. If, for example, she determines that health fairs and flu shot clinics are more successful than other options she may increase the number of such events. She may also review and determine if the methods for notifying the member are adequate and communication strategies, such as more educational mailings to the member or better coordination efforts with the PCPs should be implemented. A recent example of the organization's efforts to improve this measure is that the organization recently contracted with Walgreens for members to be able to get their flu shots.

To eliminate possible barriers to patient care, the majority of plan members may self-refer to any specialist in the network; however, the plan recommends members work through their PCP to coordinate care within their physician teams, who have established referral and communication patterns. Referrals may be required in a new service area to establish the bond between the member and the primary care physician.

Certain services offered require prior authorization from the plan (e.g., inpatient admissions, outpatient surgical procedures, home health, DME, etc.) in order to determine medical appropriateness. These services are reviewed based upon guidelines established by CMS, InterQual, and the plan's Practice Guidelines. Once an authorization is issued, a fax notification is sent to the member's PCP to ensure coordination of the member's care.

The plan has a field team of inpatient care coordinators, inpatient social workers, and SNF/LTAC Nurses that have access to contracted inpatient facilities for concurrent review to ensure proper utilization of services. For example, when a member is in an acute inpatient setting and requires continued inpatient services at an alternate level of care, the field team coordinates the medical necessity review to ensure the member is being transitioned to the appropriate level of care.

The plan also has teams that focus on outpatient procedures, home health and DME services. Internal training documents help ensure that the procedures for medical review are followed. Outpatient Trend reports are reviewed by the Medical Management Committee [which reports to the Quality, Policy and Credentialing (QPC) Committee on a quarterly basis].

The plan's practice guidelines are evidence-based, reflect current literature and research about treatment protocols, and reflect best practices as identified by the plan. The clinical practice guidelines significantly reduce variation in the clinical setting and are a component of the framework necessary for measuring and improving quality of care. Guidelines currently in place include: Preventive Care for the Adult; Anticoagulation Therapy-Warfarin; Diagnosis and Management of Hypertension in the Primary Care Setting; Diagnosis and Treatment of Benign Prostatic Hyperplasia; Management of Atrial Fibrillation; Management of Low Back Pain; Nuclear Cardiac Stress Testing; Pediatric Preventive Care; Treatment at Religious Nonmedical Health Care Institutions; Clinical Management of the Adult Asthma Patient; Daily Inpatient Physician Rounds; Diagnosis and Management of Chronic Heart Failure in the Adult; Management and Evaluation of Patients with Diabetes; Management of Hepatitis C; Management of the Abnormal Pap Smear; Chronic Obstructive Pulmonary Disease; Urinary Incontinence in the Older Adult; and Policy Precedence Guidelines.

The plan has built and continues to build clinical components of key evidence-based practice guidelines into the disease monitor system as exceptions. The Chronic Care Team runs these exceptions monthly looking for members who are not compliant with key standards of care identified in the evidence-based practice guidelines. The results of these exceptions can be resolved on a member-specific basis. Additionally, educational opportunities for the physician can be utilized to instruct the provider on the nationally accepted standards of care.

- <u>Issues DHH should include in any Request for Proposals</u>

  A. Standards that should be met for cultural competency, sensitivity to the needs of the dual eligible population and accessibility prior to enrolling recipients including:

  1. The plan should demonstrate it can make real time oral interpretation services available free of charge to each non-English speaking potential enrollee or enrollee to facilitate communication between the recipient and plan staff and/or providers. The plan should also provide written notification of these services to its enrollees and include the notice in Spanish and Vietnamese.

  2. The plan should assure that written marketing and enrollee education materials are available in Spanish and Vietnamese and have arrangements to translate these materials into other languages within 90 days without charge to enrollees. Written materials should be clear and concise and in language appropriate for the population being served.

     All member materials shall be in a style and reading level that will accommodate the reading skills of the enrollees. In general, the writing shall be at no higher than a 6.9 grade level, which is in accordance with regulations outlined in the Bayou Health RFP.

Plans should be required to provide transportation for enrollees, should work to have primary care physicians within reasonable distance of the population being served, and have clearly written protocols for accessing after hours care.

B. Evaluation of the delivery model and over what timeframe

Peoples Health feels that the evaluation methods and timeframe used in the Bayou Health program would also work well with this population.

C. Potential financial arrangements for sharing risk and rate-setting appropriate for the population and Principles that should guide DHH in requiring specific approaches for rate-setting

We would recommend that the State use the rate setting methodology for Medicare Advantage Plans for the acute care services utilized by the target population, as well as the existing Medicare methodology for "Part D" services, which includes a risk sharing component for pharmaceutical costs.

Since Medicare has little or no experience with payment for many of the services provided through Louisiana's various Home and Community Based Waiver Programs (and the State Plan LT-PCS program), we believe it will be necessary to calculate rates for these services that consider Louisiana's current payment rates, the level of need of the recipients of services, the Medicaid claims payment history, and any pertinent demographic factors. We anticipate that many of the plans that are interested in serving the targeted population may not have experience with these services and would prefer to have a shared risk arrangement for this component of the rate for at least the first one or two years following implementation.

A similar situation exists with regard to rates for those persons receiving care in an institutional setting. While Medicare pays for a very limited amount of skilled nursing facility services; the payment methodology, co-payment or patient liability requirements are vastly different from those used by Louisiana Medicaid. Therefore, our recommendation would be that DHH establish rates for that component based on the department's Medicaid claims history, patient level of need, any other risk adjustment factors the department feels are appropriate, and include provisions for risk-sharing corridors for the initial period following implementation of the program.

We recommend the Department adopt the risk sharing corridors used in the Medicare "Part D" program for both the Home and Community Based services components of the rate and the institutional component of the rate.

In our opinion, principles that should guide DHH in its approach to rate-setting should focus on the following concepts:

1. The rate should be sufficient to ensure that the dual eligible recipient can access the needed support and services to maintain their quality of life potential.

2. The rate should be sufficient for plans to appropriately reimburse providers for the provision of quality services that promote positive health outcomes.

3. The methodology should provide for fiscal accountability, require plans to use an independent outside actuary, and an independent auditor if risk-sharing adjustments are needed.

4. The reconciliation process for resolution of risk-shared payments should not exceed two years.

5. The methodology, to the extent possible, should include an interim process to assess services provided on a risk-sharing basis to make sure neither the plans nor the State are facing significant financial risks.

D. Timeline necessary for implementation

Peoples Health feels that the timeline for implementation of Bayou Health is a reasonable goal with the understanding that the State would like to expedite the process in order to achieve budget savings and the plans will be faced with significant challenges to expedite enrollment of a new group of providers. We feel that existing providers of Long Term Support and Services should be mandated to accept the current Medicaid rate for the services they provide, even if the provider is not a part of the plan's network for at least one year, unless the provider and plan negotiate other payment terms. This would prevent disruption of the recipient's existing care plan, give plans an opportunity to identify providers they want to incorporate into their care delivery networks, and arrange an orderly transition for recipients who may need changes in their existing care arrangements.

E. Potential risks and benefits of the approach proposal

We believe there will be very little risk in the approach we recommend for the acute care portion of the rate because CMS applies a risk adjustment to the base, including an adjustment based solely on the fact that the recipient is a dual-eligible. That adjustment is additionally enhanced if the recipient has additional chronic medical issues. The advantage of this approach is that the State will be able to calculate its projected expenditures for this portion of the rate.

The use of risk corridors in the institutional and/or Home and Community Based Services components should substantially reduce the possibility that plans could encounter financial difficulty during the initial implementation years. Those risk corridors should also assist the State in its budget management efforts.